

## COMPREHENSIVE ASSESSMENT

PARTICIPANTS'S

REGION:

NAME: \_\_\_\_\_

AGENCY COMPLETING ASSESSMENT: \_\_\_\_\_

DATE(S) OF ASSESSMENT: \_\_\_\_\_

ASSESSMENT BY: \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

### IDENTIFYING DATA

AGE: \_\_\_\_\_ SEX: \_\_\_\_\_ M ☐ F ☐ RACE: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_

REFERRAL SOURCE: \_\_\_\_\_

VOLUNTARY: ☐INVOLUNTARY: ☐

### LIST CURRENT TREATMENT PROVIDERS:

1. Medical physician(s): \_\_\_\_\_
2. Psychiatrist(s): \_\_\_\_\_
3. Health care providers: (Home health, PCS, Counselor/Therapist, Case Manager, Psychosocial Rehab Agency, Physical Therapist, etc.) \_\_\_\_\_
4. Other: \_\_\_\_\_

**For Children:** Submit completed copies of the first two (2) pages of the CAFAS with the Comprehensive Assessment. The initial CAFAS should reflect the prior 90-days of the youth's functioning.

(Address the following items in narrative form and attach other exams or checklists)

### PSYCHIATRIC

1. **HISTORY:** (Indicate how the mental illness impacts this area)
  - a. Age at onset: (what happened, when, impact)
  - b. Childhood and adult history of physical/sexual/emotional abuse: (who, what, when, impact on life)
  - c. Number of hospitalizations: (#, where, when, for what, diagnostic history)
  - d. Precursors of hospitalizations:
  - e. Symptoms of decompensation: (if different from Symptoms of current diagnosis)
  - f. Recipient's ability to identify symptoms:
  - g. Medication history: (what medications, dose, effects, compliance)
  - h. History of mental illness in the family: (who, what, when)
  - i. Outpatient treatment history: (where, when, for what, diagnostic history)
  - j. Symptoms that correspond to current diagnosis: (active psychosis, behavior related to the mental illness)
  - k. Developmental history/problems: (mental or physical problems)

**2. CURRENT MENTAL STATUS OBSERVATION:** (Indicate how mental illness impacts this area)

- a. Appearance: (grooming, hygiene, dress)
- b. Activity: (tension, mannerisms, motor retardation)
- c. Speech: (rate, volume)
- d. Thought process: (disorganized, altered associations)
- e. Thought content: (somatic concerns, guilt, aggressiveness, unusual thoughts, suspiciousness, grandiosity, suicidality)
- f. Perception: (hallucinations)
- g. Emotions/affect: (anxiety, mood, affect, hostility)
- h. Cognition: (concentration, reasoning, concrete/abstract thinking, memory)
- i. Orientation: (time, place, person)
- j. Judgment: (poor/good decision making)
- k. Insight: (into mental illness, awareness)

**3. SUBSTANCE ABUSE/DEPENDENCE:** (Indicate how the mental illness impacts this area)

- a. Recipient history: (what, when, how)
- b. Family history: (what, when, how)
- c. Inpatient treatment history: (medical detox, social detox, when, where, duration)
- d. Outpatient treatment history: (when, where, duration, provider)
- e. Current substance abuse/dependence: (list all substances, inhalants, oral, IV, nicotine, caffeine, how often)
- f. How substance abuse/dependence affects mental illness: (why the person takes substances, behavior problems, daily living skills, employment, relationships, finances, psychiatric symptoms, self-medication)
- g. Current treatment and/or needs: (AA, NA, CA, list other facilities/provider)

**4. FUNCTIONAL ASSESSMENT OF SKILLS AND ABILITIES TO MANAGE MENTAL ILLNESS:** (Indicate how the mental illness impacts this area)

(Recipient's ability to manage medications, recognize and cope with symptoms, follow treatment recommendations, behaviors/symptoms interfering with treatment, their acceptance of illness, ability to communicate with care providers, problem-solving skills, recipient's goals/issues. Use the information above in Psychiatric History, Current Mental Status Observation, and Substance Abuse/Dependence as supporting documentation.)

**5. DIAGNOSIS:** documented by a licensed physician or other licensed practitioner of the healing arts:

- a. Diagnosis:
- b. Physician or licensed practitioner's Name/Title:
- c. Documentation: (Attach additional information that verifies the diagnosis)

**6. Recipient's Psychiatric GOALS/ISSUES:**

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**FUNCTIONAL AREAS:**

**The psychiatric disorder must be of sufficient severity to cause a substantial disturbance in role performance or coping skills in at least two (2) of the following areas on either a continuous or an intermittent (at least once per year) basis: (see IDAPA 16.03.10.112.03.b)**

## **A. HEALTH/MEDICAL:**

- 1. MEDICAL HISTORY:** (Indicate how the mental illness impacts this area)
  - a. History of any major non-psychiatric illnesses:
  - b. Surgeries:
  - c. Hospitalizations: (what, when, why, where)
  - d. Dates of last examinations: (include physical, dental, and eye exams)
  - e. Pertinent family history of medical illness: (who, what, when)
  - f. Current health problems/needs: (allergies, interfering symptoms, keeps appointments, other)
  - g. Current prescription medications: (what kind, what for, dose, frequency, duration, compliance)
  - h. Current over-the-counter medications and vitamins:
  - i. Name of current primary physician:
  - j. Insurance: (Healthy Connections, Medicaid, Medicare, private, none)
- 2. FUNCTIONAL ASSESSMENT: Of Skills And Abilities To Manage Physical Illness:** (Indicate how the mental illness impacts this area)  
 (Recipient's ability to manage medications, recognize and cope with symptoms, follow treatment recommendations, behaviors/symptoms interfering with treatment, their acceptance of illness, ability to communicate with providers, problem-solving skills).

### **3. Recipient's Health GOALS/ISSUES:**

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## **B. VOCATIONAL/EDUCATIONAL STATUS:**

1. Current job status: (part-time/full-time, what, where, duration, wage)
2. Past job history: (what, when, where, duration, most recent, volunteer work)
3. Vocational satisfaction: (level of satisfaction)
4. Highest educational level: (high school, GED, college)
5. Military Status: (branch, rank, type of discharge)
6. Strengths to employment: (driver's license, problem solving skills, motivation, list job skills, work history, communication skills)
7. Barriers to employment: (interfering psychiatric symptoms, physical limitations, motivation, transportation, communication skills)
8. Children:
  - a. Relevant school enrollment:
  - b. School performance:
  - c. Achievement levels
  - d. School related social functioning:
9. Community work program affiliations: (Voc. Rehab., CSE, sheltered workshop, etc.)
10. Social security card and picture ID: (Does Recipient have Social Security card and picture ID)
- 11. Recipient's Vocational/Educational GOALS/ISSUES:**
12. Assessment of items 1 through 10. (Indicate how the mental illness impacts this area)

### **C. FINANCIAL STATUS:**

1. Adequacy and stability of recipient's financial status:
2. Financial difficulties of the recipient: (History)
3. Resources available: (income sources, SSI, SSD, community, family)
4. Recipient's ability to manage personal finances: (budgeting skills, debts, present and past payees, ability to pay bills, checking or savings account, cash own checks, other skills.)
5. Recipient's financial GOALS/ISSUES:
6. Assessment of items 1 through 5. (Indicate how the mental illness impacts this area)

### **D. SOCIAL RELATIONSHIPS/SUPPORT:**

1. Recipient's ability to establish/maintain personal support systems and relationships: (communication skills, family support, church, social groups, have friends, intimacy, sexual activity)
2. Recipient's ability to develop leisure, recreational, or social interests: (weekend and evening, structured vs. self-initiated, independent vs. group, level of participation, drug/alcohol activity)
3. Recipient's social GOALS/ISSUES:
4. Assessment of items 1 through 4. (Indicate how the mental illness impacts this area)

### **E. FAMILY STATUS:**

1. Family History: (give chronological record, interactive roles of family)
2. Recipient's ability and desire to carry out family roles: (list skills, communication skills, current family structure, children, parenting skills, family or origin, marital background)
3. Recipient's perception of the support s/he receives from family: (who is supportive, who is not)
4. The role the family plays in the recipient's mental illness: (is family involved in treatment, is family a resource, in what way)
5. Children
  - a. The child's functioning within the family:
  - b. The impact of the child's mental illness on family functioning:
6. Recipient's family GOALS/ISSUES:
7. Assessment of items 1 through 5. (Indicate how the mental illness impacts this area)

### **F. BASIC LIVING SKILLS. The person's ability to meet age appropriate basic living skills including transition into adulthood:**

1. Hygiene/Grooming: (showering, use soap, use shampoo, brush teeth, deodorant, shave, combing hair, etc.)
2. Personal safety practices: (use of 911, respond to emergency, recognize hazardous situation)
3. Clothing: (seasonally and situationally appropriate clothing, etc.)
4. Daily schedules: (ability to develop and follow routines, etc.)
5. Care of personal possessions: (securing property, maintenance, home security, etc.)
6. Shopping and purchasing: (shopping for best value, impulse buying, follow shopping list)
7. Meal preparation and storage: (menu planning, nutrition, kitchen skills)
8. Domestic activities: (housecleaning, laundry)
9. Basic problem solving skills: (identify problem, alternatives, pros, cons, best solution)
10. Impact of mental illness on client's ability to carry out independent living skills:
11. (For Children), include transition into adulthood:
12. Recipient's basic living skills GOALS/ISSUES:
13. Assessment of items 1 through 11. (Indicate how the mental illness impacts this area)

**G. HOUSING:**

1. Current living situation: (where, with whom)
2. Level of satisfaction with the arrangement:
3. Present situation as appropriate to the recipient's needs, their health and safety: (Is recipient able to live more independently and what supports are needed)
4. History and risk of homelessness: (types of housing, rent history, evictions and why)
5. Recipient's Housing GOALS/ISSUES:
6. Assessment of items 1 through 5. (Indicate how the mental illness impacts this area)

**H. COMMUNITY/LEGAL STATUS:**

1. Legal history with law enforcement: (parole, probation, jail time)
2. Current status with law enforcement: (parole, probation, warrants, court dates)
3. Transportation needs: (availability and accessibility; indicate the skills needed for independent living.)
4. Supports the recipient has in the community: (church, clubs, etc.; indicate the skills needed for independent living.)
5. Daily living skills necessary for community living:
6. Recipient's GOALS/ISSUES for this area:
7. Assessment of items 1 through 5. (Indicate how the mental illness impacts this area)

**I. MEDICAL NECESSITY CRITERIA:** The assessment must provide documentation of the medical necessity for each service to be provided. Medical necessity must be documented by at least one of the following criteria: description of past interventions for this issue(s) that have failed; AND/OR an explanation as to why other services are not appropriate for the clinical needs of this participant.

Statement that the services can reasonably be expected to improve the participant's condition or prevent further regression so that the current level of care is no longer necessary or may be reduced.

**1. Criteria Specific to Partial Care:**

Intensity of need must be documented by at least one of the following criteria. Please place a checkmark by any of the letters below that are documented in the assessment(s).

- a. \_\_\_\_\_documentation that participant is presently at risk for an out-of-home placement OR
- b. \_\_\_\_\_clinical deterioration that would lead to an out-of-home placement OR
- c. \_\_\_\_\_further clinical deterioration which would interfere with the participant's ability to maintain current level of functioning (if this is used then a description of the participant's current level of functioning must also be documented)

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Signature and Credentials

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Date

(This is a recommended Comprehensive Assessment template that includes all of the requirements per IDAPA 16.03.10 rule.)